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Original Department.

Lectures.

CLINICAL LECTURE ON THE USE OF THE LARYNGOSCOPE,

Delivered, April 28th, 1866, at the Pennsylvania Hospital,

By J. M. Da Costa, M. D.

[Reported specially for the Medical and Surgical Reporter.]

We have recently had several cases in the wards of the hospital of chronic laryngeal disorders, and you have seen, that both as regards their diagnosis and their treatment, the laryngoscope has played an important part. One of these cases, you will recollect, was afflicted with tubercular laryngitis, and the exact seat of the ulcerative disease in the larynx, as well as its unfortunate, and I am sorry to say unchecked, or but very slightly checked progress, was made manifest by the laryngeal mirror. In another case of ulceration, but dependent on a different cause, on syphilis, the ulceration was arrested, and the voice restored, while a very decided change in the vocal apparatus was then reflected in the mirror. In a third case we availed ourselves of the laryngoscope to ascertain if a peculiar form of stridor depended upon any appreciable lesion in the larynx, and finding the parts healthy, determined that it did not. In a fourth case, with very rigid vocal cords, subsequent to the trachea having been laid open during an attempt at suicide, we used the laryngoscope constantly to guide us in introducing a catheter between the cords, or in what is called catherization of the larynx.

But it is not my purpose so much this morning to bring before you the cases again, as it is to call your attention to the mode in which they were investigated. And I intend to devote the hour to an examination of the method of making laryngoscopic explorations. In so doing, I shall take occasion more especially to dwell upon the clinical aspect of the matter, inquiring into the value of the laryngoscope, and its availability in practice. For many points concerning its history and the like, I shall have to refer you to the numerous books which have already appeared on the subject.

The laryngoscope is nothing but a mirror, which is placed at the back of the throat, and illuminated in such a manner that the image of the larynx is formed on it. It would serve no useful purpose here to go over the steps by which the laryngeal mirror, such as we have it now, was finally perfected and introduced into practice. Sufficient to say, that though worked at by many, the subject only assumed practical direction subsequent to the experiments of Garcia, made on himself, and the application of those experiments to diagnosis by Tuerck and Czermak. To Czermak particularly is the credit generally accorded of having demonstrated the real value of the instrument.

The laryngeal mirror, as now used, is a small mirror, made either of glass or steel. Those of steel are in some respects superior to those of glass, since they give a finer image; but they easily become tarnished and rust, and, taken altogether, are far less suitable for constant use. The best shape is either round or square, and we should possess them of sizes varying from half an inch to an inch and a quarter in diameter. And let me here advise you, though you may often be obliged to use smaller laryngoscopes, to get into the habit of employing the larger ones whenever practicable, since the image they furnish is apt to be far more distinct. The mirror is attached to a thin stem from four to five inches in length, and at about an angle of 125°. For the most part it is so arranged that the metallic stem slides into a hollow wooden handle. Ordinarily, circular mirrors are best borne, and those backed with silver furnish the finest reflecting surface. The mirror, in most examinations, is held at an angle of about 45° at the back of the throat, and should be quickly introduced, and placed near, or even applied to the posterior wall of the pharynx. The quicker the mirror is introduced, and the more decidedly it is placed in contact at once with the back of the throat, the less will be the faucial irritation. But to this matter, as well as to the exact mode of passing the mirror into the throat, we shall presently

recur more in detail. Let me merely add, that in every examination to prevent the reflecting surface of the instrument from becoming clouded by the breath, this surface of the mirror should be first warmed. This may be accomplished by holding it in warm water, or, and this is preferable, by passing it over the flame of a spirit-lamp, or over that of the lamp used in the illumination of the laryngoscope. After warming it, to insure that it is not too hot, we can, before passing it into the fauces, test its heat by applying it to our own hand, or to the lips or cheek of the patient. Other plans have been suggested of keeping the mirror undimmed, such as by the aid of an electric current, or by spreading a thin layer of glycerine smoothly over its surface; but the cases are rare indeed where such a procedure becomes necessary, the only advantage of which could be, that it enables the mirror to be kept in position for a long time. Yet this is very seldom an advantage; far better is it ordinarily to withdraw the mirror and reheat it, than to annoy the throat by leaving the instrument too long among these irritable structures.

The laryngeal mirror is all that is strictly requisite for inspecting the larynx, provided we illuminate the instrument properly after having placed it in position. This can either be done by letting the rays of the sun impinge upon it, or by making use of artificial light. Either can be employed directly, or concentrated by means of a reflector on the laryngeal mirror. Though in point of fact we rarely use direct light, save when the solar rays are available. The reflector most serviceable is a circular mirror, very slightly concave, or, when solar light is employed, plane. The former is about three inches and a half in diameter, has a focal distance of about fourteen inches, and is perforated in the centre. It may be worn on a frontal band, or be attached to a spectacle frame, or to the illuminating apparatus.

Now let me briefly review the mode of procedure you have seen me employ on several patients. Supposing we wish to examine by the direct light of the sun. We place the patient, his head slightly inclined backward, with his face toward the sun, and when we perceive that the pharynx is illuminated by its rays, we introduce the laryngeal mirror, standing or sitting in front of the person examined, in such a manner as not to throw a shadow on the laryngoscope, and with the axis of vision as closely as possible parallel to the impinging rays. The back of the observer is turned toward the sun, and the rays pass by the side of his head. But you will readily see that such a position is not always a very convenient one; moreover it has to vary with the height of the sun, and the examination is much influenced by the situation of the room in which it is made. Thus, though the image we obtain by direct sunlight, is a very good one, we generally find it far more convenient to reflect the sunlight into the fauces from a small mirror attached to a stand, or from a reflector worn on the forehead. The patient sits with his back toward the window and the sun, and the observer quite close to him, facing the sun. After the back of the throat has been illuminated, the mirror is introduced and the exploration made in precisely the same manner, which I shall presently describe to you in detail, as when artificial light is employed.

I have thus explained how to effect a laryngoscopic examination by sunlight, whether direct or reflected. But you will readily understand that, as at some seasons of the year the sun is such an uncertain visitor, and even when brightly shining, it may not be in such a position as to send its rays where they can be made available, we have generally to conduct laryngoscopic examinations by artificial light. Now almost every variety of this has been used—the calcium light, gas, petroleum, the electric light, and several others. An ordinary petroleum light, or an argand gas burner is, however, generally quite sufficient, and I will describe to you how to conduct an exploration with artificial light of this kind.

To make an examination by means of artificial light, direct the patient to sit on a chair and place the flame of the lamp a little behind him, and somewhat above his mouth. Then tell him to open his mouth widely, to throw back his head very slightly and protrude his tongue. This advice is different from what you will find in many books on the subject, which recommend the use of a tongue depressor, special forms of which have indeed been devised, to facilitate laryngoscopic examinations; but as a general rule, you had better avoid a tongue-spatula. It complicates matters, and is, in the majority of cases, wholly unnecessary. The tongue is to be seized with the left hand of the examiner, covered with a soft napkin or handkerchief, and held firmly out of the mouth, or, if the patient can be trusted, he may do this; or again, he may depress the tongue on the floor of the mouth, though usually, I find the examination more satisfactory when the organ is protruded. Then, if using the ordinary means, the examiner puts on a reflecting mirror, which can be worn either on the forehead, or over the eye, like an ophthalmoscope, and looks through the central aperture. I prefer, and I know you will, for it is very much easier, to wear the reflec-

tor on the forehead. Some place it in a position which is anything but comely to look at, over the tip of the nose. To support the mirror, the frontal band attachment, answers well; but the spectacle frame of Semeleder is, in many respects, more convenient.

Having got the patient in the desired position, and the reflector well adjusted, you throw a disk of light into the back of his mouth, then heat the laryngeal mirror, and holding it at the handle like a pen, introduce it rapidly, taking care to avoid touching the tongue, to the back of the throat. When there, be sure that it presses against the posterior wall of the pharynx, or is at least very close to it; the uvula rests on the upper surface of the laryngoscope and is pushed upward. The larynx now comes into view. The skill in using the mirror dexterously, tells in applying it firmly, not hesitatingly, against the wall of the pharynx and in holding it at a proper angle. Almost all beginners err in placing the instrument in a wrong position, with the reflecting surface horizontally, or else perpendicularly. The proper angle is about 45°, and, as you wish to see different parts, you rotate it slightly from side to side. To obtain a view of the whole of the interior of the larynx at once, is indeed scarcely possible. And though you may alter the inclination of the mirror for particular views, it is better not to move it much, but to remove the instrument when the patient becomes fatigued and reintroduce it to see any special point.

This is one method of using the laryngoscope, by artificial light. But you will readily perceive the objections to it. The application of anything to your head is annoying, particularly if you have to keep your head very steady; and, on the other hand, as the disk of light will shift by the patient changing his position, you will be obliged when he moves his head to move yours. Thus, as a general rule, some more permanent fixture is desirable than is afforded by wearing the mirror on the forehead, or over the eye. With this view lenses have been introduced into laryngoscopy, to reflect light into the mouth of the patient. In the first instrument of the kind the lens was placed in front of a lamp, to throw the light directly into the mouth of the patient. This is the method the French make use of to a great extent. Doing away with the reflector on the forehead, they place the patient directly in front of a strong light, and by means of a lens concentrate the light in the fauces. Although this, certainly in steadiness of application, is an improvement over the reflector worn on the forehead, or over the eye, it has strong disadvantages. The lamp is very much in the way, especially if any application of remedies has to be made. And the same may be said of the large glass globe, filled with water, and placed before the light. To concentrate the light first on a slightly concave mirror, like that which is attached to the spectacle frame, by means of a plano-convex lens, or of a series of achromatic lenses; and then to reflect the rays from this mirror into the mouth; furnishes a far better, certainly a far more convenient mode of illumination. Lewin's lamp is constructed on the former, Tobold's on the latter plan; and they are both very good. I have had an illuminating apparatus made which I have now used for upward of a year. It consists of a clamp, which is fastened around the part of the lamp just below the flame. Attached to the clamp, and susceptible of being lowered or heightened by a screw, is a metallic rod, which supports at right angles a thicker piece of metal about eight inches long. On this slides a large bull's-eye lens, which is fixed at its proper focal distance from the flame and the reflecting mirror, the latter being attached to the other extremity of the metallic arm. A dark lantern surrounds the light, excepting where adjacent to the lens. The patient sits at the proper focal distance from the reflecting mirror, which, being arranged on a universal joint, reflects the light at any angle desired. The mirror may or may not be perforated. But in any case the observer should look from about the same point as that from which the rays are sent into the throat; should, in other words, have his eye in their exact direction; a remark applicable to every laryngoscopic examination, no matter with what means it is made, and which implies that the examiner should not sit on a higher chair than the patient. Nay, as for several purposes, for instance, for examination of the trachea, the light is best thrown from below upward on the laryngoscope, which is placed more horizontally than usual, a seat lower than that of the patient may be more suitable.

The laryngeal image will not be, at first-sight, in strict conformity with your recollections of the anatomy of the part. Thus, the epiglottis is seen in the mirror above, and with its free edge inclined somewhat forward; the anterior wall of the trachea is perceived in the same part of the laryngoscope, while the arytenoid cartilages and the posterior extremity of the vocal cords are below, in the mirror. The right vocal cord is on its left, the left vocal cord on its right. During a full inspiration the cords are wide apart, when a high note is sounded, they are close together. You can, as already remarked, very rarely get a view of all portions of the larynx at once, and

hence shift the position of the mirror in accordance with the image you wish to obtain. Of course, the degree of flexion of the patient's head, the precise position of the light and of the eye of the observer, and any peculiarities in the conformation of the laryngeal structures will also alter the angle at which the mirror should be held. But any difficulty arising from these sources may be obviated by always bearing in mind three points: 1st, the exact anatomy of the larynx; 2d, the optical law, that the angle of reflection is equal to the angle of incidence; and 3d, the absolute necessity of letting a full disk of light fall on the laryngeal mirror. I have known many examinations miscarry, or be highly unsatisfactory, from the latter cause. The disk of light is thrown into the back of the mouth, but care is not taken to see that it really illuminates completely the mirror during the laryngoscopic exploration.

There are, even if you have learned thoroughly to manage the light, some obstacles at times to overcome, which depend on the conformation of the textures. For instance, the tongue may be very thick, and rise up constantly at the back of the mouth; the uvula be very long, the epiglottis pendant, and preventing a view into the glottis. These obstacles are, however, comparatively rare; one, very much more frequent, is an irritable condition of the fauces. More or less of this is apt to be met with in every person examined for the first time with the laryngeal mirror.

It is, indeed, one of the objections to the laryngoscope, that it is not always available at the first examination of the patient, as you may have to let him undergo a course of training before you can get him to bear the instrument in the fauces. In truth, when the throat is unusually irritable, and a laryngoscopic examination is required for diagnosis and treatment, you may be obliged to train the patient for some time, touching first the lips frequently, then the tongue, and finally passing a solid body back into the throat, until you obtain perfect tolerance for the introduction of the mirror.

But you will ask me, are there no means by which it is possible to lessen the irritability of the fauces at once, so as to make the laryngoscope of service at the first examination, or to overcome that intense natural irritability sometimes met with, which even an ordinary amount of training will not be sufficient to vanquish? Taking deep breaths, while the mirror is introduced and held in position, is useful. Sucking ice will answer in some cases; a solution of tannin thrown into the throat with a spray-producer will produce some effect in others. A mixture of chloroform and morphia has been recommended, but gives rise to too violent irritation. Nor can I say that I have seen, either from the local or internal use of bromide of potassium, any decided results. Indeed, there is not a single local anæsthetic which will certainly enable us to make use of the laryngeal mirror, with ease, at once.

Finding local applications insufficient, I have tried general anæsthesia. Some time since I subjected a patient in these medical wards to etherization. Everything was ready for the examination; the sunlight was good, and all appeared favorable. But when the minute arrived at which the anæsthesia was produced; when the patients limbs were relaxed, and the snoring breathing began, success could not be obtained. The experiment utterly failed, because it was almost impossible to get the mirror into proper position, owing to the movements of the patient's head, the still partially rigid jaw, and the totally heipless state of the relaxed body. But the greatest impediment was the large accumulation of froth which took place, passing out of the larynx into the fauces, and obscuring the view.

The next day, with the kind assistance of Dr. Barker, I used nitrous oxide. The examination was readily effected, and the success was all that could be desired. I have since made several examinations in different persons in the same way, and with complete satisfaction. Yesterday some of the resident physicians witnessed the introduction of the laryngoscope in a patient under the influence of nitrous oxide. There was no difficulty whatever in placing the mirror in position: no froth; the mouth was kept widely open. There was not the least rigidity; the head was easily supported by the hand of an assistant, and the laryngoscope was held in the throat for fully one minute, the patient not being aware that it had been used, as he stated, so soon as the effect of the gas had passed off. I obtained a similar result in a patient who had by nature an extremely irritable throat. These experiments then, enable us to say, that when it is desirable, we possess, in the use of nitrous oxide, a means which will permit us to employ the laryngoscope, where otherwise it would not be borne.

Yet, understand me clearly, that in the majority of instances, means of this kind, as indeed any agents to counteract the sensitiveness of the fauces, are unnecessary. And it is astonishing how, as your own skill improves, you will find this matter more and more under your control. The more easily and the more dexterously you use the instrument, the fewer will be the cases

of irritable fauces that baffle your examination. Indeed, I now scarcely fail to obtain a view of the larynx, sufficient at least for diagnosis, in nine cases out of ten, at the first examination; whereas, when I commenced to practice with the instrument, the proportion of failures at the first attempt, was quite as large, if not larger, than that of successful explorations.

But the question will occur to you, is it worth while taking this trouble? Is the instrument of sufficient value in diagnosis and therapeutics to repay for the time and labor spent in learning its use? In regard to diagnosis, there can be but one opinion. No man now can attempt, no man certainly ought to attempt, to diagnosticate any chronic laryngeal disease, without the use of the laryngoscope, unless from some cause this instrument be not available. It would be like endeavoring to determine a disease of the heart without the aid of the stethoscope. In acute disorders the laryngeal mirror is both unnecessary, and will not be well borne by the patient. It is in chronic affections of the larynx and of the trachea that it comes so admirably into play. Infiltrations, ulcers, cicatrices, polypoid masses, etc., can be detected, which could only be guessed at without the aid of the laryngoscope, and guesses in medicine, as you well know, are often very far from the truth. But it is not simply in positive diagnosis that this instrument is valuable. We also find it of great service in what we may term negative diagnosis; in ascertaining that the supposed disease does not exist. Thus, when in a case where you suspect laryngeal trouble, you find the vocal cords opening during inspiration, and closing during the enunciation of high notes, and, indeed, readily moved by different sounds; and when the appearance of the larynx is just as it ought to be, then you know, no matter how much the symptoms point to laryngeal disease, that it is not present. This kind of information is often of very great value in the diagnosis of aneurisms for instance. The larynx being found healthy, your attention will be directed elsewhere, and the cause of the seeming laryngeal disorder traced to an aneurism. Or, take a case, which I recollect, where paralysis of one vocal cord was discovered by the laryngoscope, showing there was something pressing on one of the inferior recurrent nerves, which proved to be an aneurism. Or, let me cite an instance which came quite recently under my observation:

A young man was brought to my office, supposed to be laboring under some obstructive disease of the pharynx or œsophagus. He had been unable to swallow solid food for upwards of a month, and even liquids could not be taken without much pain, and without their regurgitating, for the most part, through the mouth. He was becoming daily more exhausted and emaciated, had a cough, and had recently lost his voice entirely. A laryngoscopic inspection showed at once the true nature of the malady. The epiglottis was enormously tumefied, and the laryngeal structures within the glottis, so far as they could be perceived, were injected. A local application of a strong astringent solution, caused at once a very marked improvement in, almost a restoration of the voice, and great amelioration in swallowing. A few more applications enabled him to take food without trouble, and all but removed the disorder. Thus you see there are many ways in which the laryngoscope will be of great value in diagnosis.

You will ask, does it aid directly in therapeutics? Can it be made the means of treating as well as of inspecting the larynx? Of course, it furnishes you indirectly with much assistance in treatment, for the more knowledge you have of any disease, the more careful, considerate and rational will be your therapeutics. But so far as local treatment is concerned, with the majority of physicians the laryngoscope will probably for some time to come not play an important part. It will remain a means of diagnosis—unquestionably its first and greatest use—rather than of therapeutics. Yet, with every one who practises, the period arrives when he learns to hold the laryngoscope in one hand, and by means of the other to touch any point he wishes with any solution that appears indicated. It is an immense improvement over passing a brush or a sponge down into the throat—in a majority of instances not reaching the larynx—thus to be able to guide the hand by the eye. But the ability to do this is not to be acquired without much practice.

When you have a steady patient, and have attained sufficient dexterity to make an application to the interior of the larynx, use for that purpose a very small sponge or a very fine brush, suitably fastened in a holder or on bent wire, and let your patient open his mouth very widely. Then, taking the image in the mirror as your guide, you pass the sponge directly over the entrance to the larynx, and if your object be to make an extended application, you quickly raise the handle to which the small piece of sponge is attached, dipping the latter straight down into the glottis. Then pressing the sponge for a few seconds against the part you wish to

touch, you withdraw the sponge and the mirror rapidly, avoiding touching the gums and tongue, If the caustic, or any other agent you may employ, is only to be applied to a particular spot, you carry the sponge until it covers in the image, as seen in the mirror, the point that you desire to reach, and, watching a favorable opportunity, press it in the required direction. Of course, applications of this kind are only required in exceptional cases.

Before dismissing the subject, let me give you a caution about local applications. Do not become meddlesome. After you have learned the use of the laryngoscope, keep your hands from interfering. Recollect that the larynx is a part of the economy, and not the whole, and therefore, because you see a little congestion, or any other slight alteration, do not set to work to apply strong solutions to it. In cases of anæmia you will find a marked pallor and anæmic appearance of the laryngeal mucous membrane. You might as well attempt to cure this by the local use of iron, as to remedy other appearances in the larynx, when they form part of a constitutional state, by local agents. The laryngoscope is no tthe plaything some believe it to be, nor the means of value above all, others would have us think. It is an instrument the use of which you ought to learn, and which will come into general employ in time, as a means of diagnosis chiefly. And it is mainly a means of diagnosis; and only when kept in its proper place, an instrument of therapeutic value.

Communications.

CASE OF BRIGHT'S DISEASE.

By James B. Burnet, M. D.,

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Louisa Monroe, nineteen years of age, a native of Long Island, single, and a domestic, was brought into Ward 26, of Bellevue Hospital, on April 30th, 1866, complaining of œdema of her lower extremities. Of herself she gave the following history: Parents are healthy, and there is no known hereditary disease in the family. Up to a few months ago she had ever enjoyed the most perfect health. Her menses made their first appearance when she was twelve years of age, and, with the exception of the period of her pregnancy, were always regular. They would continue at each period for about three or four days, and she suffered no pain whatever with them. About four months ago she was confined, and delivered naturally after an easy and short labor. A few weeks after her delivery she took a cold bath, and slept without sufficient covering, and the next morning, when she awoke, she found her feet swollen, and her limbs were quite stiff when she attempted to walk. Then there appeared a slight swelling in her lower extremities, and, in about three weeks, when she arose in the morning, she noticed that there was also a swelling under both eyes. Her abdomen also seemed to her at times to be swollen. Her bowels at this time were regular. Before the œdema made its appearance her urine was quite scanty, but after the swelling came on it was very abundant, and in color presented a sort of a dark muddy appearance. Often she was obliged to arise three or four times during the course of the night to pass her water. At times she was sick at her stomach, especially after she took her supper.

When she entered the ward, the following was her condition: She was suffering from general œdema. Her legs were so stiff that she could not walk up and down stairs. Lungs and heart healthy. Tongue natural in appearance. She complained a great deal of a constant thirst, of much pain in the small of her back, and she was troubled at times with severe vomiting. For about one month before her entrance to the hospital, there had apparently been a sort of a cloud before her right eye, but she noticed no difference in the power of vision in the left eye. Her hearing was good; her appetite was poor. She felt strong, and did not feel sleepy or drowsy. Her legs and arms, however, felt dead and heavy. Her urine was not passed as freely as was formerly the case, and was not as dark as it used to be. No particular shortness of breath, except on considerable exertion. She easily became wearied. The pulse was regular and quite strong. Her head and back ached very badly, especially in the morning and evening. The urine was examined chemically and microscopically, and found to be loaded with albumen, and also to contain hyaline and fatty casts.

The *diagnosis* of Bright's disease was made, and the *treatment* consisted in the application of dry cups over the kidneys, elaterium in one quarter grain doses, potassæ bitart, ʒij., to aquæ Oi., to be taken during the day. Tr. ferri chlor., twenty drops three times a day, and hot air baths every other day.

June 25th. Œdema is rapidly increasing. Same treatment.

During the months of July and August she remained about the same, with the exception that the anasarca had considerably decreased.

In the early part of September she gradually became worse, her strength decreased, her intellect became clouded, and she was very drowsy at times. She had no convulsions, but passed into a semi-comatose condition, in which she remained, the coma gradually deepening for three days, until death took place. A *post-mortem* examination was made, and the following were the appearances: Liver and kidneys fatty. Considerable œdema of lungs. Two pints of fluid were found in the pleural cavity. Spleen and heart healthy.

BIOGRAPHICAL SKETCHES OF Distinguished Living New York Physicians.

By Samuel W. Francis, A. M., M. D.,
(Fellow of the New York Academy of Medicine.)

IX.

Isaac E. Taylor, M. D., etc.

(President of Bellevue Hospital Medical College.)

"Each proselyte would vote his doctor best,
With absolute exclusion to the rest."—*Dryden.*

Isaac E. Taylor, M. D., was the son of William and Mary Taylor, who were born at Cambridge, England, and came to this country in 1797, settling in Philadelphia, where his father became very successful in mercantile pursuits at first, but subsequently lost much of what had been accumulated. Their family consisted of eight children, of whom two girls and three boys are now living; the subject of the present sketch being the youngest. His brother, Benjamin E. Taylor, D. D., is a clergyman; and his other brother, Dr. Othniel H. Taylor, M. D., is a physician of eminence in Camden, N. J.

Dr. Isaac E. Taylor, was born at Philadelphia, Pa., (in a house once occupied by General Washington,) 25th April, 1812, during the troubles between England and the United States. He first attended a boarding-school near Philadelphia, besides being instructed by a private tutor. He entered Rutgers College when fourteen years of age, and was at one time suspended for playing billiards; but did not remain idle during his "rustication," for he kept up with his class; re-entered the junior year, and was graduated in 1830.

During his suspension at home, he also attended a course of medical lectures on anatomy, chemistry, and midwifery; it being the last course delivered by the late Dr. P. S. Physick and Dr. James, Professor of Obstetrics.

Being now Bachelor of Arts, he at once turned his attention to the study of law and medicine, and entered the office of his brother, Dr. Othniel H. Taylor, at that time practising successfully in Philadelphia, and was in due time graduated Doctor of Medicine from the University of Pennsylvania, in 1834.

His Thesis was on Hæmoptysis. In 1840, six years after receiving his diploma, he visited Paris, and entered the office of Prof. Cazeaux, the better to learn more about those diseases which have continually interested him during his professional career.

In 1832, during that direful epidemic, he assisted in the cholera hospital in Philadelphia, of which his brother was Physician-in-Chief.*

Immediately after his marriage, in 1835, with Miss Eliza Mary, daughter of Stuart Mollau, a distinguished merchant of New York, he was induced by the earnest solicitations of his father-in-law to enter into business, and realize in a few years an abundant competency. And accordingly he became associated with him in connection with branch-houses in five of the largest southern cities. As there were many clerks, and his time was not fully engrossed, he became dissatisfied with his present mode of life, and returned to his first love, medicine, in 1839. This was much against the will of his connections, for he had the brightest prospects of making a speedy fortune, but his reply was: "I would rather make ten dollars by my profession than thousands in business." And he has ever since remained true to his determination. His family consists of one son and three daughters.

During his sojourn in Europe, he travelled extensively, attended the hospitals in Paris and Dublin, and visited other places of interest.

In 1839 he commenced to practice in the city of New York, and was attached to the City and Eastern Dispensaries, and in 1841, on his return from Europe, re-associated himself with the City, Eastern, Northern, and Demilt Dispensaries, as Attending Physician, having charge, in each, of the diseases of females. When in 1841, he attended the City Dispensary, he had private classes of four in each, attending these cases; and this was the first time that clinical instruction was given on diseases of females in the United States. Dr. Lewis A. Sayre was one of those students; and on one occasion, while he was in the office of Dr. Greene, an important case occurred, which rendered it uncertain to those medical men present, as to whether a woman had ovarian disease, a tumor of some kind, dropsy, or pregnancy, the consulting physicians present not be-

* At that time there were ten cholera hospitals in the city.

ing able to come to any definite conclusion. "Young Sayre," Dr. Taylor told me, "quietly applied his ear to the abdomen, and announced, to the surprise of all, that he heard the beating of the fœtal heart. This settled the question; and he has always since acknowledged his gratitude to me for the instruction he had received from the *clinical* advantage afforded him, through which he became acquainted with fœtal auscultation."

In November, 1840, Dr. Taylor read before the New York Medical and Surgical Society a paper on the Diseases of Females, and Nervous Diseases Treated in the City Dispensary. This was among the first papers in which mention was made of the speculum being used in the United States. It was published, at the request of Dr. A. H. Stevens, in the *New York Journal of Medicine and Surgery*, 1841. While connected with these dispensaries, during his seven years' experience, his associates in the same institutions were Drs. Swett, Bulkley, Buel, Parker, McCready, Watson, and others. He also visited the Colored Orphan Asylum for two years.

On asking the Doctor his opinion of the use of tobacco, he replied, "I occasionally smoke, and really enjoy a good cigar. Too much smoking is, like over-indulgence in all pleasure, somewhat injurious. But a moderate use of it I do not consider hurtful." The Doctor's health has been always excellent. His religious faith is Protestant, and he attends Rev. Dr. Rice's Presbyterian church.

His favorite branch of practice is obstetrics, diseases of women and children, and thoracic diseases; and he has put on record his belief that cholera is not contagious.

I asked him, one day, if he would be a Doctor again, and in answer, was told, "Yes; with all my heart I would. I love the profession." His height is 5 feet 10¼ inches, and weight about 175 pounds. He never competed for any prizes, but has studied steadily the progress of science and disease, often rising at three in the morning to prepare his lectures for the coming term, as at that hour he finds his mind clearer and more capable of grasping a given subject. Not a little of his present skill is due to his attendance on the summer school of Drs. Chapin, Hodge, Gibson, Profs. R. W. Randolfe, and Meigs. He also received a free ticket from Dr. G. S. Patterson, Professor of Jefferson Medical School, and attended one winter.

In 1851, Dr. Taylor was elected by the "Board of Ten Governors," Physician to Bellevue Hospital, his appointment having been previously suggested by the Board of Aldermen, before the Board of Governors was organized. In April, 1860, the Commissioners of Public Charities and Corrections superseded the Board of Governors, being composed of Simeon Draper, *Pres't*, Moses H. Grinnell, Isaac Bell, and James B. Nicholson, four gentlemen of integrity and energy, who have done much for the benefit of the community at large, and the poor in particular. These Commissioners brought about great reforms, and were the means of causing a complete renovation of the former system in Bellevue Hospital. The by-laws were revised and remodelled, and a Committee of Inspection was appointed, through which the Medical Board of Bellevue was represented, and by whom the principal means of communication was held with the Commissioners. It was composed of Drs. Taylor, A. B. Mott, and L. A. Sayre; Dr. Taylor being chairman. During the first meetings of this committee, important changes were effected, for Dr. Taylor suggested that the *warden* and *clerk* should not be associated with *this* committee. Under the former medical board, they had been on the executive committee, and had exercised much controlling influence. But this was now done away with, and the medical men stood on their own ground, free agents in a conscientious cause. The dead-house was now placed under the sole direction of the Committee, being a very important change for the members of the Medical Board of Bellevue; but not in any way excluding the other schools of medicine, which institutions were to be supplied with bodies in proportion to their students. And now already the benefit of past actions was perceived, for the Warden had no longer, as formerly, any control over the bodies for post mortem examination and dissection, which had once been a formidable obstacle against the attending-physicians and surgeons obtaining specimens for the purpose of illustrating their lectures in the various colleges. About this time it was noised abroad that one of the prominent physicians of one of the schools had said, "That if he could not have post-mortem examinations, except at the option of the Warden, he would resign." This did much to bring about that beneficial change.

November 25th, 1860, President Simeon Draper addressed a note to Dr. Taylor, requesting him to meet him officially, as chairman of the Committee of Inspection. Dr. Taylor went, and during the interview Mr. Draper asked him, "whether he thought the Medical Board of Bellevue Hospital would have any objections to assume the duties of medical attendants at Black-

well's Island, after the completion of the Island Hospital, which would be in a short time?" Dr. Taylor replied that he thought they would have no objection, but would accept of the medical direction there; and, moreover, stated that Dr. Sanger was then Resident-Physician on the Island, and if he deemed a change desirable, he would endeavor to effect that object.

Dr. Taylor then called a meeting of the Committee of Inspection at his house, Nov. 26th, 1860. The meeting resulted in a call "for a meeting of all the members of the Medical Board at the office, No. 1 Bond street, on Saturday, Dec. 1st, at 7½ o'clock. Present, Commissioners Draper, Nicholson, Bell, Doctors Taylor, J. R. Wood, McCready, Smith, Crane, Clark, Meyer, Gouley, Parker, Mott, Church, Green, Sayre, and Loomis."* The object of this meeting was "to unite the entire medical department of their government under *one* Medical organization, excepting only Randall's Island and the Lunatic Asylum, and embracing, besides Bellevue Hospital, the care of the patients of the Penitentiary, Almshouse, Workhouse, Island Hospital, and Small-pox Hospital."† A committee was now appointed to examine the Hospitals on Blackwell's Island. It consisted of Drs. Clark, McCready, Taylor, Crane, J. R. Wood, and Meyer, and Dr. Taylor was constituted chairman. As Dr. Clark did not serve on that occasion, Dr. Green was elected in his place.‡

On the occasion of the report of the Medical Board, Dec. 18th, 1860, after speaking of the increase of patients, Dr. Taylor said:

"As there were great opportunities for advancing the cause of medical science, thus attracting a large number of students to the city of New York, it becomes an important question, whether, ere many days elapse, the Bellevue Hospital should have—nay, ought to have—connected with it, and established, A COLLEGE for the education of young men, independent of a *Clinical* Hospital, thus making it one of the largest schools and hospitals *united together?* The question, therefore, is now put to the Medical Board, by the Committee, for their consideration, with the hope, that when the Institutions on the Island, and the Bellevue Hospital, are completely regulated, some means may be adopted to found a *university* or college similar to many of the medical institutions abroad. *There are many reasons why a college should be established*, and every exertion should be attempted to accomplish it. It will be materially aided by the Commissioners, who will be proud to come up to the work at the proper time for completion.*

"Signed,

"Isaac E. Taylor, *Chairman, etc.*"

This suggestion to establish a college was referred back to the Committee for further action, and Dr. Taylor, preferring three more to be added, nominated Drs. Stephen Smith, George T. Elliot, and Crane.

After several meetings of the Committee, it was decided to merely address a letter to the Commissioners, embodying their views, and requesting their opinion on the subject, and the best manner in which to commence their work.

Three days after this Dr. Taylor called on Mr. Draper for his answer, and it was favorable. It was simply: "All you have to do is to prepare a charter." On the strength of this suggestion Dr. Taylor drew up the charter, February 1st, 1860, and submitted it to the Commisioners and Committee of Inspection, for approval, January 11th, 1861. Those present on this occasion were Messrs. Draper and Nicholson, and Drs. Taylor, Mott, and Sayre.† The charter was read, and the Trustees named, and subsequently selected by Mr. Draper, who sent the charter to Senator Andrus, to be presented in due form to the Legislature.‡

* See Minutes of the Commissioners of Public Charities and Correction, for 1860 and 1861, vol. 1, p. 384.

† Idem.

‡ At a meeting at Mr. Keen's house, a sub-committee was appointed, composed of Drs. Taylor and J. R. Wood, Dr. Taylor acting as chairman. See Minutes of Com. of P. C., vol. 1, p. 400, appointment of Dr. Isaac E. Taylor, Visiting-Physician to Blackwell's Island Hospital for December, and p. 420 also.

* After Dr. Taylor's Report as Physician on Duty at Blackwell's Island, and Chairman of Committee of Inspection, he made the above remarks to the Medical Board, suggesting the establishing of a college in connection with the hospital, which report was separated, and is in the "Minutes of the Medical Board." Dec. 18th. Special meeting of the Medical Board at Dr. Taylor's, when the Report of the Sub-Committee (Drs. Taylor and Wood) was read by the Chairman (Dr. Taylor), and then a Committee of FIVE were appointed. To Drs. Taylor and Wood were added Drs. Stephen Smith, George T. Elliot, and Crane, as nominated by Dr. Taylor. See Minutes of Medical Board, Dec. 18; also Minutes of Committee of Inspection, Dec. 14, which met at the hospital; also Report to Commissioners, dated 15th December. The report to the Medical Board, recommending the college to be established, was a separate one, and was also read, December 14th, at a meeting of the Commissioners, and Committee of Inspection, 7½, P. M. Present—Messrs. Draper, Grinnell, Bell, Nicholson—Commissioners; and Drs. Taylor, A. B. Mott, and Sayre, Committee of Inspection. See Minutes, Dec. 14. After this the report was sent, Dec. 15th, to the Commissioners; and the other report, recommending the college, read, Dec. 18, at Dr. Taylor's house, No. 15 West 20th street, N. Y.

† See Minutes of Committee, January 11, 1861.

‡ As it will become a matter of medical history, it is deemed important that a complete list of the names first associated with this great enterprise should be incorporated in this series. The following extract from the Minutes of the Commissioners, for 1861, will prove of interest:

"An Act to incorporate the Bellevue Hospital Medical College of the City of New York, of the State of New York, represented in Senate and Assembly, do enact as follows:

John W. Francis, M. D., Isaac Wood, M. D., Alonzo Clark, M. D., Benjamin W. McCready, M. D., Isaac E. Taylor, M. D.,

March 29th, 1861, as Chairman of the Committee on the College Dr. I. E. Taylor addressed a note to Mr. Draper, requesting that action be taken with a view to erect a building at once, etc. (page 161, vol. 2), and was answered the same day by Mr. Draper, President, requesting him to present, in detail, their wishes on the subject.

This was answered, April 8th, 1861, by Dr. I. E. Taylor and B. W. McCready, Committee of Medical Board, and a definite explanation as to their object made. I make the following extract in explanation, as pertinent: "It is intended that the Bellevue Medical College, though possessing a faculty taken from the Medical Board, shall be an institution entirely separated in its government from that Board. The faculty of the new college occupying themselves as a faculty only with the instruction of students, leave the present relations between the Board of Commissioners and the Medical Board altogether unchanged (see page 164, vol. 2.) Permission to erect a hospital was soon after accorded by the Commissioners, and the plans submitted by Messrs. Post and Gambrill, architects, were adopted. About this time Dr. Taylor applied for leave to visit Europe, but owing to certain reasons did not go.

The Trustees and faculty met at his house, April 25th or 26th, 1861, and it was on this occasion that Dr. Taylor suggested, that instead of erecting a new building, it would be more economical for the present, to alter the old Dead House, where also the Museum was. This was stated by Mr. Draper, and was agreed upon. The Committee of the Building, appointed, at a meeting of the Medical Board, in April, at Dr. Isaac Woods' house, reported that plan.

From this time matters took a practical turn, but nothing of any especial interest occurred till May 5th, 1863, when Dr. Taylor suggested establishing the Out-door Department (see page 209, vol. 3 & 4, Min. of Commissioners.) This arose from the following circumstances. April 21st, 1863, Mr. Draper sent a communication to the Medical Board on Specialities, and a regular meeting was held, April 29th,* approving of them. Thus, as specialties were objectionable to outer schools, and sustained by members of the Medical Board of Bellevue Hospital, Dr. Taylor proposed an Out-door Department, which would meet both ends in view. May 10th, Drs. Flint, Jr., and Taylor, suggested that Mr. Draper call a special meeting of the Medical Board of Bellevue Hospital to reconsider the subject of specialties.† This was held. The next meeting was at No. 1 Bond street,‡ and a special meeting was held at Dr. Isaac Woods', June 10th or 11th, and a Committee of two were elected to report on the subject, as proposed by the Commissioners, at their office, June 8th. This Committee consisted of Drs. Clark and Flint. They reported: Dr. Clark preparing the part on Operatives of the Hospital (page 227), and Dr. Flint that which referred to the Out-door Department. This report set aside the specialties of hospitals as prepared April 21st, 1863, and passed unanimously (see pages 203 & 234, *idem.*)

President Draper soon after made some excellent remarks concerning out-door Poor, and their wants,‖ and in talking over the matter with Dr. Taylor, it was decided that the "Out-door Department" should in future be recognized by the name of "Bureau of Medical and Surgical Relief," which it now bears. Nothing of importance occurred till April 6th, 1865, when active measures were adopted concerning this Department.§ Also November 10th, 1865, the Executive Committee of B. H. M. College were very much interested in this movement. The taking of immediate steps was strongly advocated by Mr. Nicholson, one of the Board of Commissioners; and Isaac Bell, President, called a meeting, and requested Dr. Taylor, ex-officio, to organize the Bureau. Everything looked favorably, but it was at length superseded in its action by other influences. At a regular meeting, May 7th, 1866, a report was

George T. Elliot, M. D., B. Fordyce Barker, M. D., Alfred L. Loomis, M. D., John W. Green, M. D., Theodore G. Thomas, M. D., Valentine Mott, M. D., Alexander H. Stevens, M. D., James R. Wood, M. D., Lewis A. Sayre, M. D., John J. Crane, M. D., Stephen Smith, M. D., Willard Parker, M. D., Alexander B. Mott, M. D., Carl Theo. Meier, M. D., John W. S. Gouley, M. D., William H. Church, M. D., and their associates, are hereby constituted a body corporate, by the name of the Bellevue Hospital Medical College of the City of New York, of the State of New York, for the purposes of instruction in the various departments of medical science, professed and taught by said College.

"2. Simeon Draper, James B. Nicholson, Isaac Bell, Jr., Moses H. Grinnell, John J. Astor, Moses Taylor, William B. Crosby, John Ward, Samuel D. Cook, George F. Tallman, Edward Minturn, J. P. Geraud Foster, Anthony L. Robertson, E. H. Chapin, John Hughes, Robert T. Haws, Richard M. Blatchford, Robert L. Hone, James T. Brady, Watts Sherman, and Matthew Morgan, are hereby constituted a Board of twenty-one Trustees, etc. * * * * *

"10. This Act to take effect immediately."

* See pages 203-5-8-9, and 10, Minutes of Commissioners, 1863, vols. 3 & 4.

† See page 214, Minutes of Commissioners.

‡ See page 222, Minutes of Commissioners.

‖ See page 254, Minutes of Commissioners.

§ See vol. 6, Minutes of Commissioners, P. C. & C., pp. 101, 112, 115, and 586-7-8.

made to ISAAC BELL, President, and the Commissioners, and was adopted.*

This Bureau was organized June 23d, 1866, and soon went into full operation, June 28th, 1866. A communication from Dr. ALEXANDER B. MOTT, Secretary, "Transmitting proceedings† of meeting held June 22d, 1866, for the organization of the Bureau for 'Medical and Surgical Out-Door Relief,' which was held at the house of Dr. I. E. TAYLOR, 13 West 20th street." * * * *

Extract from the Minutes:

"On motion of Dr. SAYRE, Dr. TAYLOR was called to the chair.

"On motion of Dr. FLINT, Dr. MOTT was appointed Secretary.

"Dr. WOOD moved to proceed to the election of President and Secretary of the organization. *Carried.* The balloting resulted in favor of Dr. I. E. TAYLOR for President, and Dr. A. B. MOTT for Secretary.

"On motion of Dr. GOULEY, the votes for President and Secretary were declared to be unanimous." * * * * * *

Names of Medical Staff.

PHYSICIANS.	SURGEONS.
Alonzo Clark, M. D.	James R. Wood, M. D.
Benjamin W. McCready, M. D.	Alexander B Mott, M. D.
Isaac E. Taylor, M. D.	Lewis A. Sayre, M. D.
George T. Elliot, M. D.	John J. Crane, M. D.
Alfred L. Loomis, M. D.	Stephen Smith, M. D.
John W. Greene, M. D.	J. W. S. Gouley, M. D.
Theodore G. Thomas, M. D.	Frank H. Hamilton, M. D.
Austin Flint, M. D.	H. A. Sands, M. D.

About this time, though the several Institutions on Blackwell's Island were under the immediate supervision of the Bellevue Hospital Board, it was not considered, by the Commissioners, to bring about such successful issues as they had anticipated, in its relations with the Island Hospital, Small-Pox and Fever tents. Accordingly it was proposed that the matter should be taken under consideration, and Dr. TAYLOR was requested to make any suggestions that he might deem conducive to the condition of the patients, more supervision and aid being required. In one instance no case of instruments could be found, while Drs. J. R. WOOD and TAYLOR were officially inspecting the four Hospitals, and on this occasion Dr. WOOD was obliged to probe a fistula in ano in the Almshouse Department, by the aid of a knitting needle.‡ Dr. TAYLOR accordingly proposed an outside and independent organization, with the additional member of the Board. The following explains itself:

"NEW YORK, March 12, 1866.

"DR. ISAAC E. TAYLOR:

"*Sir*—You are respectfully requested to call together the members of the New Medical Board of the Island Hospital, at as early a period as possible, for the purpose of organization, and to nominate the House-Staff for the ensuing season.

"The newly-chosen members of the Island Hospital Board have been notified of their election.

"Yours truly,

ISAAC BELL, *President.*"

The permanency of Bellevue Hospital College would not have continued an established fact, had not the out-door Department been suggested, for this, in not a few points, reconciled opposing elements and opened a field to the interested. At present the building is erected and a lease given, which offers complete security against outside pressure, and the majority of difficulties are overcome, legal and political resistance proving of no avail, "to the contrary notwithstanding." Any promoter of so useful and successful an enterprise must contemplate its advancement with feelings akin to rapture. In speaking of this College and its surroundings, Mr. MOSES H. GRINNELL, one of the Commissioners, and a member of the Board of Trustees during its commencement at the Academy of Music, said "that the college was established four years ago by the Commissioners of Charities at the suggestion of the President, Professor TAYLOR. Great good had already been accomplished through its instrumentality, * * * *. He asked the citizens of New York to give the college, which he believed to be unequalled by any in the country, their cordial support."*

The New York Medical Journal Association held its first meeting at his house, where Dr. STEPHEN SMITH and himself first proposed its organization, (see page 72, *Medical Register*, N.Y. 1866.) This has grown to be a most useful enterprise, and the library is now placed in the Mott Memorial Building; a munificent donation to the profession and city, by the widow of the late Napoleon of surgery, whose instruments and books may be judiciously used.

For three years Dr. TAYLOR investigated closely the practice of Homœopathy, with the conclusion that it was excellent treatment for diseases which would get well of themselves, and had produced

* See Pamphlet of Minutes, May 17th, 1866, page 222. Dr. STEPHEN SMITH acted as Secretary on this occasion.

† See Minutes of Commissioners, etc., page 331, June, 1866.

‡ See Letter of Dr. I. E. TAYLOR to Commissioners. Minutes, Vol. I, page 422.

* At the opening of the Bellevue Hospital Medical College, for the Session 1866-7, Prof. A. B. MOTT, M. D., etc., while delivering the Introductory Address, October 10th, 1866, stated some interesting facts:

The College was founded and opened in 1861, and its number of medical students increased in the following manner:

	Students.	*Graduated.*
Session, 1861-2,	121	——
" 1862-3,	183	41
" 1863-4,	307	94
" 1864-5,	323	111
" 1865-6,	470	171

Is there another institution in this country whose growth has been as rapid, and its facilities so abundant?

one benefit, to wit: the lessening of those old-fashioned heroic overdoses, which, in carrying off disease also washed away health. Among many of his characteristics, those peculiarly prominent, are punctuality and earnestness, his love for his profession, diffidence and marked courtesy to those with whom he comes in contact. His library contains many valuable works, published in France, Germany, and the United States.

As a lecturer he is full and general, at times going into details that at first seemed superfluous, but during the lecture bear with additional power upon his subject.

List of Dr. Taylor's Medical works:

1. Report of Cases of Diseases peculiar to Females and Nervous Diseases, treated in the New York City Dispensary—read before the New York Medical and Surgical Society in November, 1840, and published at the request of Dr. Alexander H. Stevens in the New York Journal of Medicine and Surgery, Vol. 4, for January, 1841. This was among the first papers in which the use of the speculum was mentioned.
2. Edited Dr. Evory Kennedy's Work on Auscultation, with numerous plates and notes, unfolding the views entertained by Stoltz and Cazeaux, concerning the Cervix Uteri, 1843.
3. Remarks on the use of "Liquor Hydriodate of Arsenic and Mercury in Cutaneous and Uterine Diseases." This was its first introduction to the notice of the Profession at large. Published in the American Journal of Medical Sciences, for April, 1843.
4. On Rheumatism of the Uterus and Ovaries—read before the Pathological Society in New York, March 12, 1845, and published in the Journal of Medical Sciences, July, 1845.
5. Report of cases of Aphonia and Syphilitic Ulceration of the Larynx, treated by the Sponge Probang, with solution of the Nitrate of Silver, read before the New York Medical and Surgical Society in April, and published in the May number of the New York Journal of Collateral Sciences, 1845. This paper was the cause of a committee being appointed, which consisted of Drs. Buck, Swett and F. C. Stewart, who were to report as to their view on the propriety of introducing the Sponge *Larynx*, saturated with a solution of Nitrate of Silver, into the Larynx. Soon after, Dr. Green read his paper before the same Society, on Topical Applications, May, 1845.

   In speaking to me on this subject, Dr. Taylor unhesitatingly asserted that it was his firm conviction after much observation and no little experience, that in *very few cases* was the physician successful in introducing his sponge etc., etc., into the Larynx, it being his misfortune almost invariably to pass it into the œsophagus, which is almost always sure to be the result. This is an important fact, and worthy of experimental investigation.
6. Paper on Protrusion of the Eye, resulting from Rheumatic Inflammation of the Tunica Vaginalis Oculi, in New York Medical Times, June, 1845.
7. Protrusion of the Eye, or Exophthalmus, and Enlargement of the Thyroid Gland, as a sequence of Anæmia. New York Medical Times—with a plate—December 1852.
8. Syphilitic Mucous Tubercles and Secondary Syphilitic Affections of the Os Uteri; and Hereditary Transmissions. New York Journal of Medicine, May, 1853, and republished in several German Journals, and read before the Society of Medical Inquiry, April, 1853.
9. Monograph on the Sunburnt Appearance of the Skin, as an early diagnostic sign of the Supra Renal Capsule Disease. Published with illustrations in the New York Journal of Medicine, September, 1856.
10. Remarks on a case of Regurgitation of the Stomach, successfully treated by the inhalation of Chloroform. Published in New-York Journal of Medicine, Nov., 1856.
11. Case of Labor with anteversion of the Uterus in that state. Published in New York Medical Times for September, 1856.
12. On two successful cases of Recto Vaginal Fistula, cured by a new operation. Published in New York Medical Times, 1856.
13. Observations on the non-shortening of the Supra and Infra Vaginal Portion of the Cervix Uteri to the full term of Gestation. Read before the Academy of Medicine, and published in the American Medical Times for June, 1862. Illustrated with morbid specimens and diagnosis.
14. Case of Procidentia Uteri of fifteen years' standing, successfully treated by being replaced, showing the error of the so-called large Hypertrophies of the Cervix Uteri, which is only an eversion of the cervix. Read before the County Medical Society, New York, and published in the New York State Medical Transactions, 1864.

15. Monograph on "Placenta Prævia" with a *resumé* of the various opinions thereon, etc., etc. Read before the County Medical Society, February, 1865, and published in the State Transactions for 1865. There are many errors in the paper as it appears in the State Transactions, but these have been rectified in a new and revised edition, published by Dr. TAYLOR in quarto form, and elegantly printed and illustrated by excellent engravings.
16. Monograph on Recto Vaginal and Recto Labial Fistula, operated on after a new method. Published in the New York State Medical Transactions, for 1866.

Hospital Reports.

PHILADELPHIA HOSPITAL, *October*, 1866.

SURGICAL CLINIC OF WM. H. PANCOAST, M. D.

Specially reported for the MEDICAL AND SURGICAL REPORTER.

Pathological Specimens.

Cancer. I here show you, gentlemen, an interesting pathological specimen of scirrhus deposit. The patient, an elderly and fat woman, afflicted with incurable blindness, about eighteen months ago found a small lump appearing in the left mammary gland, near the nipple. She felt no pain until about three months since, when the lump ulcerated, and an abscess formed in the left axilla. From the involvement of the axillary glands the cancerous poison soon rapidly spread through the glandular system, and when she came into my service in this hospital, I found her in a most deplorable condition: both breasts enlarged and indurated; the glands in the axilla of both sides affected, and so much so on the left side as to interfere, by their pressure, with the circulation, and producing enormous œdema of the left arm. The poor sufferer was very patient, but she was so prostrated, and I deemed the glandular system so thoroughly involved, as to render any operation useless, and could only make her as comfortable as possible. If she had not been so weak I intended showing her to you as an example of the cancerous cachexy. She died very suddenly from the rapid supervention of hydrothorax, a sequence of an attack of pleurisy. In these specimens that I show, you can see how the enormous and sudden effusion of serum had compressed the left lung, there being found two and a half gallons of serum in the left plural cavity. The right lung but partially compressed, this pleural cavity containing but a small amount of fluid. There were ten fluid ounces of serum in the pericardium. The heart was normal. There were fourteen gall-stones in the gall bladder. The surface of the body presented a waxy appearance, and the superficial fascia of the abdomen was one inch thick. The cancerous deposition is general in the body, showing that if any operation had been performed upon the breasts that it would have returned elsewhere. The left mammary gland was fastened immovably to the subjacent fascia, and the pectoralis major and minor, and the fascia of both sides, infiltrated with cancerous deposit. The microscope revealed cells crowded with nuclei and nucleoli, which I consider a more certain indication of the malignant character of the disease than the mere caudated shape of the cell; also, however, we have the spindle shaped, broad, oval, and caudated cells, their presence proving the existence of the cancer; but their absence, when we have this crowded and distended condition of the cell, not disproving the existence of cancer.

The kidneys were affected, and a large cyst is upon the apex of the right one, and it is very much engorged. You see here how red and congested is the structure around the Malpighian pyramids, as well as the cortical portions. The ovaries are in a state of cancerous degeneration, as well as the fibrous coat of the liver. The liver is small, and there are adhesions between its serous covering and the parietal peritoneum. This then, gentlemen, was a case in which it would have been foolish and cruel to have operated, and may well be called a *noli me tangere.*

Tubercle. These pathological specimens which I now show you are from an insane patient, who died suddenly from violent hemorrhage from the lungs, due to the opening of some blood-vessel in the neighborhood of this extensive abscess, which I here show you, as it enlarged itself by progressive ulceration. This patient was not in the surgical wards, but comes from the medical service. But according to the history of the case, furnished me by my assistant, Dr. MEARS, he was transferred to the medical wards suffering from pneumonia. These specimens are interesting, showing to you the results of tuberculosis. The presence of these tubercles, the size and appearance of this cavity in the left lung, lead us to believe that the patient was suffering for some time previously with phthisis pulmonalis, and that the pneumonia, which you see has been general, being superadded, was more than the weakened lungs could bear. The smaller blood-vessels even, overdistended with blood, and softened by ulceration, might have burst, and poured out a sufficient quantity of blood to have destroyed the patient in his enfeebled condition, so that it is not necessary to believe that the vessel opened was a large one.

We have also in these lungs, in the various states of engorgement and inflammation, excellent specimens of the three stages of pneumonia. Here, in the least congested part of these inflamed lungs, I show you simple engorgement, engorgement in the first stage of the disease.

In this part, where the engorgement also exists, the lung is loaded with watery fluid, and hence softened so that you can thrust your finger readily into its substance, is the second stage; the one of red softening, ramollisement rouge—red hepatization.

Now in this part where there has been suppuration, the substance has a gray appearance from the effusion or infiltration of pus, and represents very accurately the third stage; gray softening or

gray hepatization; the ramollisement gris of Andral and Lænnec.

Here I show you an evidence that the tuberculosis was general in this section of the brain, for, on the arachnoid membrane covering it, here are tubercles distinctly to be seen.

Fracture of the Clavicle.

Now this patient has had fracture of the right clavicle, near the arcomial end, but, as the poor woman did not have it set properly at the time when it was broken, the deformity has resulted which you see. The length of this clavicle measured from the sternum is, you see, evidently much less than on the sound side, more than an inch difference, owing to the over-riding of the fragments at the point of fracture; and we can feel the large lump made by the callus which united them. The shoulder, you see, is lower, and seems more forward than on the sound side. The clavicle is the key-bone to the shoulder, its only bony connection with the thorax, and acting as a fulcrum to the arms as levers, gives man all those motions of climbing, embracing, grasping, etc., which are only common to those animals having this long support to the shoulder. Therefore, when this support is gone, by the fracture of the clavicle, the shoulder falls forward and downward, and the arm is almost useless. Then the fragments will override each other, and if not kept in position, one will have this deformed appearance that you see, and this bony mass of callus. Hence, you see the importance of holding the shoulder upward, backward, and outward, the indications for the treatment of this fracture by appropriate dressing, so as to make a neat adjustment of the fragments, and a perfect recovery.

Granular Conjunctivitis.

These two men that I now bring before you, are two cases of granular conjunctivitis. You saw them at my last clinic, when I brought so many cases of conjunctivitis in different stages before you, from the simplest congestion and inflammation of the conjunctiva to the most direful results of the disease. The Eye Ward is filled with these cases, many of which come into the Almshouse for support when the ravages of the disease have destroyed their sight, so that we can do but little for them. And in showing them, I impressed upon you the importance of attending to conjunctivitis in time, and of your paying especial attention to the cases shown and their treatment. And if you learn how to cure granular conjunctivitis, you will have mastered a most important point in clinical instruction, and will render yourselves most valuable members of any community, wherever you may reside. For what a glorious privilege it is to save an eye, to restore a patient from a living death to life again, to all those numerous enjoyments that come through the transparent cornea.

Yet in these two patients you see the cornea clouded; in one, the cornea of one eye is so opaque, from the interstitial deposit of plasma, that no light can pass through it. He is blind in it. When the opacity is slight, resulting only from the deposition of plasma in the cellular tissue or lamina of the cornea, we call it albugo, but when it is the dense white opacity, as you see in this eye, resulting from the cicatrization of wounds or ulcers, we call it leucoma; so you see it is a difference but of degree, depending only on the severity of the ophthalmia and the consequent amount of deposition of plasma. No practical difference.

Now how is this opacity produced? How was this eye lost? In a healthy eye, the cornea is a clear transparent window, no bloodvessels can we see in it. We even teach that it is a non-vascular structure, nourished by imbibition from the capillary blood-vessels that terminate in loops at its circumference; and yet here I show you in the eyes of these two patients bloodvessels permeating the cornea in great number, shooting over from the circumference to the centre. In this eye you see a large bloodvessel, almost the calibre of a fiddle-string, permeating the very substance of the cornea, and softening it. What must be the consequence if neglected or badly treated? Why an effusion of plasma, a destruction of the cornea as great as in this eye, which is lost. An opacity, a heavy curtain, shutting out all beauty from the recognition of the mind, and a curtain which then cannot be raised.

Now what is the condition of these eyes? When I evert the lids, as I now do, one after the other, you see these heavy granulations, this thickened condition of the palpebral conjunctiva; that is the cause. In simple conjunctivitis, cold in the eye, we can readily, in healthy subjects, relieve the irritation and congestion of the bloodvessels of the conjunctiva, if we see it in the first stages, often with simple astringents, and cooling or soothing lotions, with rest. But when the inflammation has lasted for a long time, in broken-down constitutions especially, or when badly treated, we will find that delicate lining of the eyelids which ordinarily moves so gently over the ball, so delicate that the smallest particle of dust will interfere with its smoothness of motion and produce friction, to become more and more congested and inflamed until the palpebral conjunctiva will become thickened with granulations, which will stand out in irritating protuberances, as you see in these cases of granular conjunctivitis, rendering the lids like nutmeg-graters painted a bright-red. What must result, then, but increased and more violent inflammation, from the friction; the conjunctiva covering the ball will become more and more inflamed until every minute capillary is enlarged, and the whole cornea one mass of bloodvessels, as you see in this eye, and then, if not arrested, that most dreadful of calamities, blindness.

Now can we save these eyes? Can we restore the transparency of the cornea? Can we reduce the redness of the ball? Can we restore this nutmeg-grater to smoothness? I think we can. The eyes that you have already seen are improved, and I think we can benefit and cure these. But no simple soothing lotions alone will do it. We must relieve this congestion. The eye must be scarified, and if that will not do, I will shave off some of these granulations. When the intense congestion is relieved, why then our lotions will have some effect, and not till then. I not only scarify the ball at the circumference of the cornea, but here you see me cut the cornea itself,

and how the blood wells out from a structure where we say there should be none. I have frequently tapped the cornea in this way in such cases, and though I have seen no one else do it, yet I am satisfied that it is right in such cases, and I have never seen anything but good result from the practice. For when the cornea is so congested as you see in these cases, cutting the continuity of the vessel at the circumference is not sufficient. The blood-vessel, as you see here, remains distended with blood, and you wish that relieved as quickly as possible. When it is emptied, as you now see, and the continuity of the vessels destroyed, the palpebral conjunctiva thoroughly scarified, as I now do, you relieve the violence of the inflammation in the most rapid manner possible, by a bloodletting at the very focus of the inflammation. We will now let these patients bathe their eyes in warm water, so as to encourage all the bleeding possible; and after that we will apply to the eyes a collyrium of

℞. Strychniæ, gr. i.
Acid. acetic., gtt. ij.
Aquæ rosæ, f.℥j. M.

and let it be dropped in the eyes four to six times in the day. This I find a very useful collyrium, when there is so much photophobia as you see in these cases.

I will let them apply warm or cold water, or pieces of ice to the eye, whichever is the most agreeable to the sensation, and from time to time a starch poultice, warm or cold, as long as it is pleasant. They will be kept in a dark room, and as they are in an atonic condition, I will build them up, and give them quinine. When the effect of this wash is exhausted, I will change to other eye lotions, for I find that in these chronic cases we have to generally ring the changes; when one eye-wash fails in its efficacy, then change to another. I shall bring these cases again before you, and report the progress of the cases in the Eye Ward.

Phymosis.

I now show you, gentlemen, three cases of phymosis. Two of these are acute, and by the ulcerated edges and the characteristic appearance of the patients, especially this one, upon whom the secondary condition is so well marked, you will at once recognize the syphilitic cachexia. Now these are cases requiring operation, for from the indurated feeling of the prepuce, we at once recognize the presence of ulcers concealed beneath the prepuce, which the injections thrown within the prepuce do not seem to cure.

Now if there was only one little Hunterian chancre hid in this manner, so as not to be amenable to treatment, it would be a reservoir of the syphilitic poison sufficient to impregnate the whole system. So, what is our bounden duty? Why to bring these chancres into a position so that they can be cauterized or cut out. Therefore, in both these cases, I will slit up the prepuce, and turning it open, will expose the ulcers which here exist, so that we can treat them.

In performing this operation, I carefully introduce a groove-director under the prepuce, as far back as is necessary, being very careful that it is only between the prepuce and the gland, and not in the urethra, which mistake would entail the splitting up of the glans penis. Being sure, then, of the position of my groove-director, and laying the back of my knife in its groove, I cut at once through the prepuce. In this manner, in this other patient, also you see I expose the glans perfectly, and by everting the prepuce, can make whatever application is necessary to the chancres. I at once, however, immediately after the incision, apply this chloride of zinc to the edges of the wound, cauterizing them, and preventing their becoming inoculated. It is for this reason that I only open the prepuce, and make no attempt to improve the appearance by trimming off these dog's-ears on either side of the glans. When the chancres are cured and the prepuce in good condition, I can then make another operation for that purpose.

The operation I will then perform as I now show you on this colored boy, who has this bad phymosis of long-standing. The orifice is so small that I can just introduce the groove-director, when it should be large enough to allow the glans penis to pass freely. With the same precaution I have just mentioned, I cut through the prepuce on the director, and now trim off these dog's-ears nicely, around even to the frenum præputii, and nicking the frenum, I tear it down, thus preventing hæmorrhage, and giving full motion to the prepuce over the glans. To make this present a natural appearance, and because the mucous membrane is so altered and thickened, I trim it closely down, leaving only a hem all around the glans; to this hem I now fasten, by a sufficient number of sutures, the skin, and invert it in this manner upon the glans, and when union takes place, the skin will gradually change its character to that of mucous membrane, and we will have a capital prepuce.

Gunshot Wound of Foot. Amputation.

This colored patient, John W., aged 26 years, of Newbern, North Carolina, was wounded about two and a half years ago, the ball entering on the heel, and being removed through an incision just opposite the internal malleolus; the wound had healed up. When a child he suffered severely from white swelling at this ankle joint. His father was affected with the same disease in both ankles. This ankle of the patient has always been larger than the sound one, and, when admitted, it was 16 inches in circumference, and the other 10 inches. A case of chronic synovitis, which progressed from bad to worse. You see how enormously swelled is this lower portion of the leg, the many sinuses, some of them leading down to a necrosis of the lower third of the tibia. The pus is fœtid and sanious, characteristic of the condition of such a patient, of a marked strumous diathesis, thin, feeble, and losing flesh every day. He has been in the house some weeks, and in the hands of my colleagues, assistants, and myself, everything has been done to build him up, so that his health might rally, and enable us to save his limb and his life. My assistant, Dr. Mears, reported that he was gradually failing, and, in consultation with my colleagues, we have decided that his best and only chance is to have the source of irritation, and

this drain upon his system, removed. The result, however, will be doubtful, as he is in such an unfavorable condition for any operation; but, as he will die if this drain is kept up on his vitality, I consider it my duty to give him a chance for his life by amputating the limb. As the necrosis seems extensive, and the tissues much altered, I will amputate at this point, the junction of the middle with the upper third of the leg. I propose to make a flap operation, and as I can make a long flap on the outside of this left leg, saving as much tissue as possible, and I fear the bone is much diseased, I will perform the rectangular flap operation of Mr. Teale, of Leeds, England, which he told me he preferred for nearly all amputations, making them on the thigh and arm. I think, however, the place of election for his form of the flaps is on the lower part of the leg and forearm. It seems to suit the necessities of this case, and I will make the long flap according to his law, the length of one-half the circumference of the limb at the point of amputation, and the short flap which is meant to contain the most important vessels and nerves, one-eighth the circumference of the limb. My assistant holds the leg up, as you see, to drain the limb, and to save every drop of blood we can, encouraging the draining by friction toward the body. The patient is now under the effects of the anæsthetic. The tourniquet is tightened, and we are now ready. I have marked in ink the lines of the incision, so you can see them and understand the operation. The instruments I need being at hand, my scalpel, saw, forceps, and tenaculum, while my assistants have the ligatures, needles, retractor, and dressings ready; and seeing that the tourniquet is well secured on the femoral artery, I commence. I enter my scalpel at the junction of the middle and upper third of the leg, a little to the inside of the crest of the tibia, and, pushing it to the bone, carry my incision down on the tibia to the margin of the ulcerated surface; now holding the skin back firmly, I carry my knife across at right angles to the incision just made, and cutting down to the bone to a little on the outer side of the fibula, I now turn my knife again at right angles, and cutting down on the posterior and outer surface of the fibula. I complete the long flap, and dissect it up from the bones to the points where I entered, and withdraw my knife; now holding my knife firmly in my grasp, I rapidly make the posterior flap, cutting down to the bones, and dissect this short flap up. Holding back with these flaps, I loosen them a little, so they shall draw up a little further, so that the bones shall be well covered, and passing my knife between the two bones, I am now ready for the saw. Applying the retractor, one tail being drawn between the bones, and drawing the flaps well back, I apply my saw, so that it shall go through both bones at the same time, without splintering the bone, and the operation is performed. Now putting the flaps together, you see what a capital stump this should make, coming up neatly together, and covering admirably the bones. We will now ligate the vessels. As the tourniquet is loosed, you see how the vessels in these lardacious looking flaps ooze, and how softened the vessels are. I am glad that we have plenty of flap, as they look unhealthy, and may slough; it would not, however, have been justifiable to have gone further up; and trusting that we will be able, by careful nursing and good diet to support our patient, trust for the best. He seems much prostrated, though he has lost but little blood. We will leave the flaps open for a while, until all the oozing is arrested, and then drawing them together with silver wire, which I do not think here any better than the well-waxed silk ligature, some of which we will also use. I will support the flaps with good adhesive strips, and covering the stump with a light dressing, put it at ease on a pillow, so that it can draw easily. We will give the patient at once half a grain of morphia, and repeated in one-eighth grain-doses every hour, while necessary. I will report to you the progress of the case, whether favorable or not, and will now conclude the clinic of the day.

Editorial Department.

Periscope.

Chloride of Copper—Its Medical uses.

Dr. Th. Clemens, of Frankfurt, a. M., has communicated, during the past twelve months, several articles to the columns of the *Deutsche Klinik*, on the use of a spirit of chloride of copper as a disinfectant and as a prophylactic in cholera epidemics. He asserts that it is an established fact, supported by experience, that workers in copper-mines and in copper fabrics remain protected against the cholera poison. He claims that this substance has a peculiar effect upon the abdominal ganglionic system. In chronic diarrhœa, in irregularities of alvine evacuations, in lead colic, in hypochondria, and the cardialgic paroxysms of hysterical girls, he has used it with the result of curing them often, in a short time. He gives from three to six drops every morning, in a mouthful of light wine. In the summer-complaint of children, in addition, he rubs it over the belly. He has also employed it in typhus. He has also employed the vapor of chloride of copper. He also uses it as a lotion in suppurating wounds. It is made by dissolving two drachms of chloride of copper in two pounds ordinary spirits, and then adding to the solution half an ounce of chloroform. To produce the vapor, this is burned in an ordinary spirit lamp. If there is no lamp at hand, roll some cotton-wool on a plate, moisten it with a drachm of the spirit, and set fire to it.

In large hospitals, it can be placed in the halls and allowed to burn all day long. As a lotion, two drachms of the chloride of copper to two pounds distilled water. Moisten charpie with this and lay it over the wounds. When the spirit is used externally, it must be rubbed in well so as to create a feeling of warmth, and produce a tonicity of the nervous system of the skin.

Dr. Clemens claims this material to be the strongest, quickest, and most continuous disinfecting medium known.

A good way to disinfect a room is to put out a

coal-fire by throwing chloride of copper water over it.—*Druggists' Circular.*

Reviews and Book Notices.

Elements of Medical Chemistry. By B. Howard Rand, M. D., Professor of Chemistry in Jefferson Medical College. Philadelphia: T. Ellwood Zell & Co., 17 and 19 South Sixth Street. 12mo., pp. 399.

Dr. Franklin made it a maxim to "avoid all unnecessary actions." If he had made it also to include unnecessary *words*, and could have enforced it upon all authors, especially, what pyramids of paper, and seas of ink might have been saved! We are reminded of this by the fact that the successor of Dr. Franklin's grandson, in the highly honorable position of Professor in the Jefferson College, has just presented, in this book, a model of brevity. It is well remarked in his Preface, that it would have been an easier task to produce a larger volume. Being "a full set of notes of the author's course of Lectures," it must become an indispensable hand-book to all of his pupils.

Professor Rand has long held, as he has deserved, a high position as a teacher of Chemistry. We doubt the existence of his superior in this country as an instructor of medical students in that department. The simplicity, clearness, and absence of all superfluity, which characterize his lecture-room demonstrations, are seen in this book from the beginning to the end. We have only to regret, now and then, an *excessive* curtailment; which, for some readers and beginners, not among his own students, leaves the work not absolutely complete. As so good and useful a manual will bear hypercriticism, one or two of these may be noted.

Thus, (p. 15), *matter* is defined as "anything that can be grasped in the hand." Can *air*, or any gas, or even a liquid, be *grasped* in the hand? The definition should or might have been, "anything perceptible by our senses." Again, in the brief account of chloroform, (pp. 309–10), no mention is made of its anæsthetic property. Though, as it is said, "its uses are too well known to be detailed," yet this property is mentioned in the cases of ether and nitrous oxide. By the way, the word "anæsthetic" does not occur in the glossary, at the end of the book. Neither does "notation," "nomenclature," nor "symbol," etc.; so that, convenient as the glossary is for its purposes, and notwithstanding the fulness of the list of contents, we would judge that an Index ought to have been added. No account of the unitary system of notation, nor of any of the new views which threaten to revolutionize chemical theory, as well as nomenclature, occurs in the book. Prof. Rand is undoubtedly right in teaching at the present time systematically upon the "older notation, nomenclature, and equivalents, as best adapted for elementary instruction." But some brief mention of the views proposed and adopted by several very eminent chemists would have been well.

This last omission has of course been one of deliberate design. The author's care and industry in bringing up his text-book to the day in its facts, is shown by his description of "atomization," and of local anæsthesia by rhigoline, as well as by ether; and by his full account of nitroglycerin. This last term suggests, as a minor point, that we are sorry not to have Prof. Rand's authority (as a lover of brevity in *orthography*) for omitting the final *e* from all such words. In this book we have, on one page, *acrolein*, with glycerine, nitroglycerine, and glonoine; and, elsewhere, *salicin*, *phloridzin*, with quinoidine, caffeine, (caffeina, p. 339); *fibrin*, *casein*, *gelatin*, *kreatin*, with kreatinine. It is true that *quinine* has become so much a common and commercial word as not to be changeable; in all the rest we would go with those authorities who dispense with the superfluous terminal vowel.

As an especially good point in Prof. Rand's book, we would remark upon the due apportionment of space to its different subjects; not, as in another late manual issued from the press of this city, giving an inordinate amount of room to physics; which, after all, is rather from practical necessity than scientific propriety, allowed a place in a chemical treatise or course of lectures. Further, a commendable precision, of great use to the medical student, is observed in designating the terms employed in the last edition of the U. S. Pharmacopœia; and the relative medical or chemical importance of different substances is very well indicated by typographical distinctions.

The Publishers have done full justice to Prof. Rand's book, by issuing it upon beautifully tinted paper, extremely well printed, and with, not many, but as far as they go, good illustrations. Although Fownes' will be very hard to displace from general use, medical students may feel themselves greatly indebted to Prof. Rand, for furnishing them with a Text-book so portable, convenient, and concise, and yet so lucid and full as to the really essential elements of chemistry.

Medical and Surgical Reporter.

S. W. BUTLER, M. D., *Editor and Proprietor.*

PHILADELPHIA, OCTOBER 27, 1866.

WHAT WE HAVE DONE SINCE JULY!

Our readers cannot help observing that this journal is made the constant medium of familiar, pointed, practical communications on all subjects of interest to medical men. A brief analysis of the sixteen numbers of the current volume already issued since the first of July last, shows the following facts. Of long articles, occupying say from one to four pages each, we have published *sixty-four*, or an average of *four* to each number. Under the head of "Hospital Reports," the same number of clinical cases have been published; that is, an average of *four* in each number. Many of these have been very important, instructive cases. *Forty-seven* articles, on various topics, have appeared in the Correspondence department. These articles are generally short, pointed and instructive; and coming, as they do, from men who are in active every-day practice, most of them being country practitioners, they give the Reporter a practical value to the medical man, that is possessed by no other medical periodical in this country. The three departments named, have alone, in a little more than three months, given the profession no less than *One Hundred and Seventy-five articles*, an average of about *eleven a week;* all of them original, and emanating from men engaged in the active duties of the profession, in every section of the country. Besides these, these numbers contain Reports of Medical Societies, Periscope, Reviews of Books, Editorial articles, and News and Miscellaneous articles, too numerous to do more than refer to now, and all calculated to instruct and interest the profession.

Were we disposed to make invidious comparisons, we might place the contents of the Reporter in contrast with those of other journals, and, we flatter ourselves, much to its advantage. But the profession have the discrimination to judge of the comparative value of the various journals, and have honored the Reporter with their patronage from every section of the country, until it has become as truly cosmopolitan in extent of circulation, as it has always aimed to be in spirit. We are thankful to receive these evidences, that we are acceptably fulfilling a mission which was almost unwittingly assumed sixteen years ago.

The above thoughts were suggested by the following, which we extract from a business letter recently received from a professor in a city in one of the western States:

"Perhaps there is no medical journal in this country that is read by a larger number of medical students than the Medical and Surgical Reporter. I heard one remark, only the other day, that although there were five medical journals taken at the office where he studied, yet the Reporter was more generally read than any of them, and the reason assigned for it was, that the matter which it contained, nearly all came fresh from the hands of those who were engaged in the active duties of the profession. Keep it thus, and you will never want for active support among the working members of the profession."

A large amount of testimony of a similar character could be adduced, to show how much is thought of the Reporter by its readers. We are thankful that a liberal support has given us the means to do as much as we have done, and we only long for the ability to do still more. This we will be enabled to do as our circulation extends, and therefore bespeak the active coöperation of all our readers in adding to our subscription list, and thus add still more to the literary value of the Reporter.

Notes and Comments.

The Death of Dr. Brainard.

Dr. Daniel Brainard, of Chicago, a distinguished surgeon, and Professor in the Rush Medical College of that city, died of cholera, on Wednesday, the 10th inst. He had but recently returned from a prolonged absence in Europe.

Dr. Brainard has long occupied a prominent position in his profession, having for many years been a leading teacher of medicine in Chicago, a surgeon of considerable ability, and for some time editor of the *Chicago Medical Journal.* The lectures in the Rush Medical College were suspended a week, in consequence of his death.

A Liberal Offer.

We have on several occasions spoken in commendatory terms of the *Galaxy*, a fortnightly magazine published in New York, which is a very creditable addition to our American periodical literature.

The second volume begins with the issue for November 1st. The publishers make the liberal offer to all who purchase that number, to give with it a pamphlet of 165 octavo pages, containing the first twenty-six chapters of "The Claverings," Anthony Trollope's latest and best novel,

which is still being published in each successive issue of the *Galaxy*. Purchase this number as a specimen from a news-dealer, or send thirty cents to the publishers, W. C. & F. P. Church, 38 Park Row, New York.

A New Artificial Leg.

We have examined an artificial leg invented by Dr. H. L. Byrd, formerly of Savannah, Georgia, now of Baltimore, Md. The improvements claimed are in the socket, and supporting cylinder. The socket is made of a perforated material, allowing free ventilation to the stump. The limb is light, and by an ingenious contrivance has some lateral, as well as forward and backward motion at the ankle-joint. Dr. Byrd has formed a partnership with Mr. D. W. Kolbé, of this city, for the manufacture of this leg.

Correspondence.

FOREIGN.

Dublin, September 29th, 1866.

Cholera. Mixed Fevers.

Editor Medical and Surgical Reporter:

It is almost impossible to think or write about anything except cholera and its belongings, not that other diseases have vanished from amongst us, as is generally thought to be the case during a cholera epidemic; on the contrary, other epidemic diseases seem to be on the increase. Typhus and typhoid fevers, scarlatina, diphtheria, small-pox, and erysipelas, all seem to be more than usually prevalent; and the cholera, so far from diminishing the fatality of these affections, seems to have impressed them with some of its own malignancy.

There have been several instances in the hospitals where typhus fever, erysipelas, and typhoid pneumonia, have assumed unusually malignant characters, defying all treatment, and rapidly running into a state of choleraic collapse. A case at present in hospital, under the care of Dr. Grimshaw, exhibits a remarkable example of what has been stated above. A boy, aged sixteen, was admitted, on September 20, with all the characteristic symptoms of typhus well marked; the boy was ill six days, dating from the first rigor. His father died from cholera, after a few hours illness, on the day previous to his son's admission. The case went on, as such cases usually do, until September 22, when choleraic symptoms developed themselves. The pain and gurgling on pressure over the cœcum, being well marked, and the characteristic discharges being present, but no rose spots could be discovered, the skin being covered with the mulberry rash of typhus.

As such cases of mixed fever are common at present, Dr. Grimshaw treated this patient as he had done others of the same kind. On the following day, on Dr. Grimshaw's visit, he found the patient exhibiting all the signs of cholera—cold surface, vomiting, and purging, but no cramps worthy the name. The next day the symptoms continued the same—the boy vomited a large lumbricus. After this the vomiting and purging ceased, but the state of collapse has become worse and worse, until the present time, when the glands of the neck became swollen, and there is every appearance of rapid sinking of the vital powers beyond all hope of recovery.

A case of erysipelas followed the same course under the care of Dr. Handy; as did also a case of pneumonia under Dr. Grimshaw's care. A case of typhus lies at present in the hospital presenting similar characters.

As to the progress of cholera here, the number of cases during the past week have increased, but not to such an extent as to cause me to alter the opinion expressed in my last letter, that we are likely to escape a serious epidemic this year. The number of deaths for the weeks ending September the 15th and 22d have been respectively 55, an increase of three on the previous week, and 65, an increase of ten on the previous week. The returns for the month will, I apprehend, be much the same as for last. The treatment of the disease seems to have had much the same success as on former occasions, being apparently more successful as the epidemic advances.

The only new remedy for cholera lately proposed has been tincture of Callabar bean (*physostigma venenosum*), introduced to the notice of the profession by Dr. Mapother, the Medical Officer of Health for the City, through the columns of the *Medical Press and Circular*. Although very few cases have been reported, yet there is sufficient evidence in favor of the remedy to warrant a further trial. But, as the treatment is founded on the supposed truth of Dr. Johnson's theory of cholera, it seems very questionable whether, on further trial, the bean will be found to possess properties superior to other cholera medicines in use at present.

T. W. G.

—— Dr. John Brown, of Edinburgh, author of Raab and his Friends, Spare Hours, a popular work on Health, and other works, was recently announced as having become insane. We are glad, however, to notice that he has recovered and has resumed his ordinary duties.

News and Miscellany.

Medical Prescriptions through the Atlantic Cable.

The London *Lancet* says:—"Amongst the uses to which the Atlantic cable has been put is one which would hardly be anticipated. A correspondent communicates to us a telegram which he received from a patient who, being seized with a renewed attack of illness, from which he had suffered in this country, and for which he had been successfully treated, telegraphed to his old medical attendant for directions. These were returned by the same channel without delay, and we hope they have prospered, and that the proper remittance will follow by an early packet. This prescription will rank among the curiosities of telegraphy."

—— Mortality of New York. Dr. Harris in his weekly communication to the Board of Health, states that the mortality in New York for the week ending October 14th, was equal to an annual death-rate of 28 7-10ths per thousand inhabitants, excluding public institutions. He says this is a more favorable showing than that of the leading European cities. The death-rate in Liverpool for the third week in September was at 52 per thousand annually; in London, 23; Manchester, 30; Vienna, 43.

MARRIED.

Bailey—Dougal.—At Milton, Pa., on the 11th inst., by the Rev. Dr. Watson, Robert M. Bailey, of Baltimore, Maryland, and Elizabeth E., youngest daughter of Dr. James Dougal, of Milton.

Bliss—Mathison.—At Brattleboro', Vt., October 10, by the Rev. A. C. Stevens, Flavel N. Bliss and Maggie, daughter of Dr. R. Mathison, of Middletown.

Branson—Gillingham.—In this city, on the 11th inst., by the Rev. Treadwell Walden, Orlando Branson and Ellen Comegys, daughter of the late Dr. W. H. Gillingham.

De Hart—Kanouse.—At Boonton, N. J., Oct. 9, by the Rev. D. E. Magie, assisted by the Rev. J. N. Jansen, Dr. John N. De Hart, of Pompton, and Lizzie, daughter of J. L. Kanouse, Esq., of the former place.

Fell—Curtis.—In this city, on the 16th inst., at the Church of the Atonement, by Rev. Benjamin Watson, D. D., Edward R. Fell, M. D., and Margaret Stewart, eldest daughter of Jos. Curtis, Esq.

Fitch—Hutchinson.—In Milford, N. H., October 11, by Rev. Mr. Ayer, Dr. F. P. Fitch and Isabella A. B. Hutchinson, daughter of the late Dr. Jonas Hutchinson.

Harlan—Holman.—At Dedham, Mass., on the 10th of October, by the Rev. Samuel Babcock, George C. Harlan, M. D., of Philadelphia, and Mary D. Holman, of Dedham, daughter of the late Dr. Holman.

Townsend—Huckins.—In Watertown, N. Y., September 27, by Rev. Mr. Bean, Rev. L. Townsend, of Malden, and Laura C. Huckins, daughter of T. C. Huckins, M. D., of Watertown.

Wick—McElvain.—October 4th, by Rev. J. H. Marshall, Dr. J. N. Wick and Miss Maggie J. McElvain, all of Concord, Butler county, Pa.

Young—Hopple.—On the 10th inst., at Moscow, Ohio, by the Rev. W. T. Moore, Mr. William A. Young, of New Orleans, La., and Miss Anna M., daughter of Dr. James Hopple, of Moscow.

DIED.

Fagan.—At Boonton, N. J., October 1, Anne Maria, youngest daughter of Dr. Henry M. and Esther Fagan, aged 1 year and 2 months.

Petherbridge.—In Westfield, N. J, October 10, Elizabeth A., wife of John B. Petherbridge, M. D., aged 39 years.

Warren.—In Boston, October 11, at his residence, No. 3 Avon Place, D. K. Warren, M. D., aged 45 years.

Ward.—Suddenly of paralysis, at Newark, N. J., October 4th, Julia J. Ward, daughter of the late Dr. John Ward, of

OBITUARY.

Dr. R. W. Gibbes.

The death of Dr. R. W. Gibbes, of Columbia, S. C., is announced as having taken place in that city on the 15th instant. Dr. Gibbes was born in Columbia on the 8th of July, 1809, and graduated from South Carolina College in 1827. He studied medicine, married a daughter of James S. Quignard, and settled in his native city, where he lived a life of usefulness for nearly forty years. He was twice Mayor; and at one time acted as assistant professor of chemistry at his own *alma mater* with such success that he was offered a professorship, which he declined. His tastes and habits were literary and scientific, and he contributed largely to the medical and scientific journals of the country. His name is honorably mentioned by Humboldt in his "Kosmos," and by Audubon in his Ornithology. The Smithsonian Institute tendered him the publication of his plates on paleontology and fossil remains at the cost of the Institute. He was also the author and compiler of several volumes of the Documentary History of South Carolina. He was eminently public spirited; and to escape heavy loss, it became necessary for him to become the publisher of *The Columbia South Carolinian*, which he edited for several years. He lost severely by the burning of Columbia—his fine mansion, with its valuable collection of paintings, fossil remains, and geological specimens, falling a prey to the flames. He leaves a numerous family of sons, daughters, and grandchildren.

ANSWERS TO CORRESPONDENTS.

Dr. T. C. L., Middletown, Pa.—Our charge for binding the Reporter, library style (half morocco), is $1 per volume.

Dr. W. B. B., Margaretta Furnace, Pa.—Surgeons of New York, sent by mail, 19th inst.

Dr. W. H. B., McKees ½ Falls, Pa.—Apparatus for producing local anæsthesia, rhigolene, sulphuric ether, and hypodermic syringe, sent by Express, 15th inst.

Mr. T. C. D., Washington, D. C.—Dublin Practice of Midwifery, sent by mail, 20th inst.

Dr. G. P., City Point, Va.—Pereira's Prescription Book, sent by mail, 20th inst.

Dr. A. A. H., Spurn Village, N. J.—U. S. Pharmacopœia, sent by mail, 20th inst.

Dr. A. J. C., Stewartsville, Mo.—Churchill on Diseases of Women, and Ellis' Medical Formulary, sent by mail, 20th inst.

Dr. G. W. H., Newville, Pa.—Da Costa's Medical Diagnosis, sent by mail, 20th inst.

Dr. O. H. P., Milford, Ga.—Da Costa's Diagnosis, sent by mail, 20th inst.

Dr. B. C. C., Quindaro, Kansas.—Knee band, sent by mail, 19th inst.

Dr. L. F., Middle Valley, N. J.—Ashton on Rectum, glass speculum, and horse-shoe pessary, sent by Express, 20th inst.

Dr. S. B. C., Walkerton, Ind.—Auricles, sent by Express, 23d inst.

Dr. D. H., Elmira, N. Y.—Bartholow on Spermatorrhœa, and Sims on Uterine Surgery, sent by Express, 20th inst.

Dr. R. S. W., Brady's Bend, Pa.—Ophthalmic Surgery, by Lawrence and Moon, sent by mail, 20th inst.

Dr. W. J. B., Shreve, Ohio.—Da Costa's Medical Diagnosis, sent by mail, 20th inst.

Dr. L. M, Bellevue, Iowa.—Thumb-lancet, sent by mail, 20th inst.

Dr. H. A. S., Gallatin, Tenn.—Dunglison's Dictionary, and Ludlow's Manual, sent by mail, 20th inst.

METEOROLOGY.

October,	8,	9,	10,	11,	12,	13,	14,
Wind	W.	N. E.	N. E.	N. E.	N. E.	N. E.	N.
Weather	Clear.	Cl'dy.	Cl'dy.	Cl'dy. Rain.	Cl'dy. Rain.	Cl'dy. Rain.	Clear.
Depth Rain				5-10		1 4-10	
Thermometer.							
Minimum	52°	55°	50°	48°	44°	45°	41°
At 8 A. M.	60	64	57	55	53	52	51
At 12 M.	71	62	62	60	57	57	58
At 3 P. M.	75	60	59	58	57	55	57
Mean	64.50	60 25	57.	55.25	52.75	52.25	51.75
Barometer.							
At 12 M.	30.2	30.3	30 2	30.	29.9	29.9	30.2

Germantown, Pa. B. J. Lekdom.